OAAS Support Coordination Documentation (SCD)

Monthly Contact Documentation

Case No: _____ Participant: _____ Service Log No. _____

SC ID: Activity: _____

_____

Date: _____ _____

Begin Time: ____: ____ (hh: mm) Service Participants: _____

End Time: ____: ____ (hh: mm) _____

Place of Service: _____ _____

Type of Contact: _____ _____

MFP Residence Code: Travel Log Begin Mileage:_____

End Mileage: _____

MFP Lives with Family Code:

Are there any changes in the contact information? If "Yes", list below in narrative and change in CMIS.

Answer each question, record the participant's/responsible representative's (RR) answers and describe in the narrative.

	YES	NO
1. Were there any changes to medications or treatments since last contact? If YES, describe below.	☐	☐
2. Were there any changes in who is available to give the participant's medication or treatments since last contact? If YES, describe below.	☐	☐
3. Were there any major changes in the person's life that have affected or could affect their health and welfare (risk factors) since last contact? If YES, refer to *Community Choices Waiver Risk Assessment & Referral Screening Tool* enter the results below.	☐	☐
4. Was a strategy, action and/or POC change implemented to **address** a newly identified risk factor? If YES, describe below.	☐	☐
5. Was there a substantial change in the participant's condition since last contact? If YES, or unsure refer to *Change in Status Checklist & Decision Making Guide* and enter the results below.	☐	☐
6. Was an MDS-HC performed since last contact? Date:_____	☐	☐
7. Was the POC revised since last contact? Date:_____	☐	☐
8. Did the participant or responsible representative (RR) state that the participant's needs are currently being met? If NO, describe below the identified need(s) which are not adequately addressed and reference CAPS as applicable.	☐	☐
9. Was a new or ongoing need **addressed** during this monthly contact (reference CAPS as applicable)? If YES, describe below.	☐	☐
10. Does the participant or RR state that the participant's goals and preferences are being respected? If NO, describe below.	☐	☐
11. Does the participant or RR state that services are delivered at the participant's preferred times?	☐	☐
12. Were actions taken to address the participant's goals and preferences? If YES, describe below.	☐	☐
13. According to the participant or RR, have there been any critical incidents since you last contacted them? If YES, describe below.	☐	☐
14. According to the participant or RR, have there been any problems receiving all services in their POC (e.g., DSW fails to show up, Environmental Modifications not completed)? If YES, describe below.	☐	☐
15. According to the participant or RR, have there been any problems accessing one or more services in their POC (e.g., problems getting to the ADHC)? If YES, describe below..	☐	☐
16. Were actions taken to resolve problems accessing services in the POC. If YES, describe below.	☐	☐

	YES	NO
17. According to the participant or RR, have there been any problems accessing health care services (e.g., primary care physician, eye doctor, dentist, hospital)? If YES, describe below.	☐	☐
18. Were actions taken to resolve problems accessing health care services? If YES, describe below.	☐	☐
19. Have there been any staffing issues? If YES, summarize below.	☐	☐
20. Have there been any changes in who would be available to assist during an evacuation? If YES, describe below.	☐	☐
21. Has there been a caregiver status change or changes to informal support substantial change in condition for any of the participant's family caregivers since your last contact? If YES, describe below.	☐	☐
22. Was a new Caregiver Assessment performed? If YES, summarize below.	☐	☐
23. Were any new strategies or interventions developed or implemented to address an issue(s) identified through the "Caregiver Assessment"? (such as those listed in the "Caregiver Assessment Decision Map Job Aid") If so, describe below.	☐	☐

Monthly Contact Narrative:

SC Signature: _____Date: _____